

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificate.

1 PLACE OF DEATH

4499

County

A A B

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Annapolis

(No.

137 St John

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Eliza Bailey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH

May 9, 1914

7 AGE

If LESS than

1 day.....hrs.

yrs.

mos.

ds.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis Md

10 NAME OF FATHER

Charles Bailey

11 BIRTHPLACE OF FATHER (State or country)

Annapolis Md

12 MAIDEN NAME OF MOTHER

Lizzie Day

13 BIRTHPLACE OF MOTHER (State or country)

A. A. B. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Bailey

(Address)

Annapolis Md

15

Filed

May 24, 1914 Jms Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 22<sup>nd</sup>, 1914

17 I HEREBY CERTIFY, That I attended deceased from

May 9<sup>th</sup>, 1914, to May 22<sup>nd</sup>, 1914that I last saw her alive on May 22<sup>nd</sup>, 1914and that death occurred on the date stated above, at 6<sup>30</sup> m.

The CAUSE OF DEATH\* was as follows:

Constitutional Debility  
(Duration) yrs. mos. ds.

Contributory

Since birth Exhaustive Gracinal

(Signed)

John Ridout, M. D.  
May 23, 1914 (Address) Annapolis, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewer Hill Cent May 24, 1914

20 UNDERTAKER

ADDRESS

Jas L. Laylor &amp; Son Annapolis Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

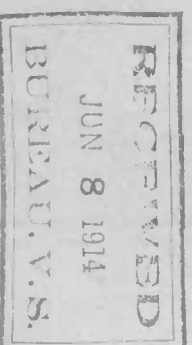
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Anne Arundel</u> <sup>4500</sup> <sup>CH3</sup> <sup>(92)</sup>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Fairfield</u> (No. <u>-</u> )		Registered No. <u>24</u>	
2 FULL NAME <u>Mary S. Bailey</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>July</u> <u>-</u> <u>1880</u> (Month) (Day) (Year)			
7 AGE <u>34</u> yrs. <u>-</u> mos. <u>-</u> ds.		If LESS than 1 day, <u>-</u> hrs. OR <u>-</u> min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>-</u>			
9 BIRTHPLACE (State or country) <u>Balto. Md</u>			
PARENTS			
10 NAME OF FATHER <u>John Bailey</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>			
12 MAIDEN NAME OF MOTHER <u>Margaret Dilliey</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Margaret Bailey</u> (Address) <u>Fairfield Md</u>			
15 FILED <u>May 30<sup>th</sup></u> 1914 <u>V. B. Horton</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May</u> <u>28</u> , 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY That I attended deceased from <u>May 7</u> , 1914, to <u>May 28</u> , 1914, that I last saw her alive on <u>May 28</u> , 1914, and that death occurred on the date stated above, at <u>3a</u> m. The CAUSE OF DEATH* was as follows: <u>Pneumonia (Lobar)</u> <u>Lobar Pneumonia</u> <u>J. B.</u> (Duration) <u>-</u> yrs. <u>21</u> mos. <u>-</u> ds. Contributory <u>Heart Failure</u> (Duration) <u>-</u> yrs. <u>21</u> mos. <u>-</u> ds. (Signed) <u>C. H. Brown</u> , M. D. <u>May 30<sup>th</sup></u> , 1914. (Address) <u>714 S. Main St</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>-</u> yrs. <u>-</u> mos. <u>-</u> ds. In the State <u>-</u> yrs. <u>-</u> mos. <u>-</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>-</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Laurel Cmn</u>		DATE OF BURIAL <u>May 31</u> , 1914	
20 UNDERTAKER <u>John H. Todman</u>		ADDRESS <u>142 W. St</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coating*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ad-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUN 5 1914  
BUREAU U. S.



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1 PLACE OF DEATH			4501		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Anne Arundel</u>					Registration Dist. No. <u>22</u>	
Village or City <u>Jessup</u>			(No. <u>61</u> )		St.; Ward	
2 FULL NAME <u>George A Barnes</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>May 13, 1884</u> (Month) (Day) (Year)						
7 AGE <u>30</u> yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>Baltimore Md</u>						
PARENTS	10 NAME OF FATHER <u>Thomas P. Barnes</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Balt. Md</u>					
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Geo. A. Barnes</u>						
(Address) <u>619 S. Montford Ave.</u>						
15 Filed <u>May 18, 1914</u> <u>L. H. Haslam</u> REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May 17, 1914</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, that I attended deceased from <u>May 13</u> , 191 <u>4</u> to <u>May 17</u> , 191 <u>4</u> that I last saw him alive on <u>May 16</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>6 P</u> m. The CAUSE OF DEATH* was as follows:						
<u>Cardiac Inmate</u> (Duration) yrs. — mos. — ds.						
Contributory <u>Meningitis</u> (Duration) yrs. — mos. — ds.						
(Signed) <u>L. W. Bouey</u> , M. D. <u>May 18, 1914</u> (Address) <u>Sever Md</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)						
At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.						
Where was disease contracted, If not at place of death?						
Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>St. Carmel Cem.</u>				DATE OF BURIAL <u>May 19, 1914</u>		
20 UNDERTAKER <u>Wendell Lippel Bros</u>				ADDRESS <u>330 S. Bond St.</u>		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

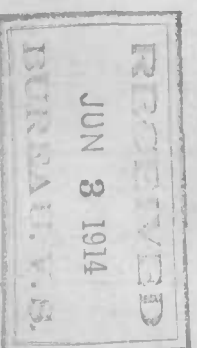
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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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PLACE OF DEATH

4502

County

A. A. Co.

Village or City

Annapolis (No. Emergency Hs. St.; Ward)

Registration Dist. No.

21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Wm. C. Brooks

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH

Aug 15, 1893 (Month) (Day) (Year)

7 AGE

20 yrs. 9 mos. 18 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Student.

9 BIRTHPLACE (State or country)

Middle town Md

## PARENTS

10 NAME OF FATHER

Wm. C. Brooks

11 BIRTHPLACE OF FATHER (State or country)

Middle town Md

12 MAIDEN NAME OF MOTHER

J. V. Givens

13 BIRTHPLACE OF MOTHER (State or country)

Frederick Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. C. Brooks

(Address)

Middle town Md

15

Filed

May 29, 1914 Jms Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 28, 1914 (Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h alive on , 191,

and that death occurred on the date stated above, at 2 P m.

The CAUSE OF DEATH\* was as follows:

Homicidal  
gun shot wound  
of abdomen with perforation  
of intestines (Duration) yrs. mos. 3 ds.

Contributory (Secondary)

peritonitis

(Duration) yrs. mos. 2 ds.

(Signed) Wm. H. Meade J. Corning

May 28, 1914 (Address) Eastport Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frederick May 29, 1914

20 UNDERTAKER

ADDRESS

Worley &amp; Son 12 Morris Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

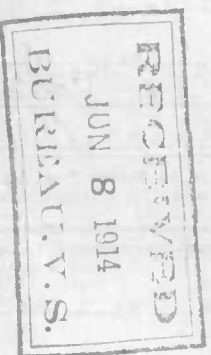
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**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4503  
County Anne Arundel  
Village or City Crownsville State Hospital (No.        St.        Ward       )

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sophie Brooks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown, 1897  
(Month) (Day) (Year)

7 AGE 17 yrs. Unknown mos.        ds.        OR        min. ?  
It LESS than 1 day, .... hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Unknown  
(b) General nature of industry, business, or establishment in which employed (or employer)       

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER John Brooks

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records  
(Address)       

15 5/26, 1913  
Filed        REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1913, to May 23, 1914,  
that I last saw her alive on May 23, 1914.

and that death occurred on the date stated above, at 10 P. m.  
The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
(Duration) Unknown yrs.        mos.        ds.

Contributory  
Secondary

(Signed) Robert R. Myer, M.D.  
May 25, 1914 (Address) Crownsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 10 mos. 10 ds. In the State Unknown yrs.        mos.        ds.  
Where was disease contracted, Unknown  
If not at place of death?

Former or usual residence Talbot County Md

19 PLACE OF BURIAL OR REMOVAL Hospital Cemetery DATE OF BURIAL May 26, 1914

20 UNDERTAKER R. A. Winkler ADDRESS Wabersburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

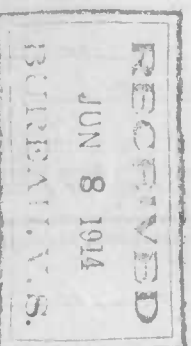
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Cancer*,

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4504

County A. C.

(10)

## STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 20Village or City Marys (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Joseph Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH June 3, 1838  
(Month) (Day) (Year)

7 AGE 76 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farm Hand  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

ind

## PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER  
(State or country)

ind

12 MAIDEN NAME OF MOTHER

don't

13 BIRTHPLACE OF MOTHER  
(State or country)

ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Brown(Address) Marys

15

Filed May 23, 1914 by John Callison  
Sul. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1914, to May 20, 1914.

that I last saw him alive on May 20, 1914

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

La Grippe

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) John Callison, M. D.  
May 23, 1914 (Address) South River Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hope ChapelMay 22, 1914

20 UNDERTAKER

ADDRESS

Jas. J. Levy Davidson

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

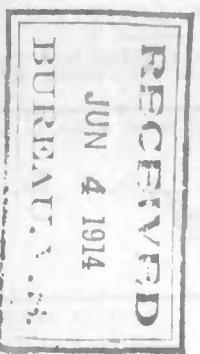
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <u>4505</u>		STATE OF MARYLAND	
County <u>A. A.</u>		CERTIFICATE OF DEATH	
Village or City <u>Annap. Jct.</u> (No. _____)		Registration Dist. No. <u>22</u>	
2 FULL NAME <u>Katherine C. Brown</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>May 27<sup>th</sup></u> , 191 <u>4</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>June 19<sup>th</sup>, 1877</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended deceased from <u>May 27<sup>th</sup></u> , 191 <u>4</u> , to <u>May 27<sup>th</sup></u> , 191 <u>4</u> , that I last saw her alive on <u>May 27<sup>th</sup></u> , 191 <u>4</u>	
7 AGE <u>36</u> yrs. <u>11</u> mos. <u>8</u> ds. <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ?		and that death occurred on the date stated above, at <u>8:20</u> p. m.	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)		The CAUSE OF DEATH* was as follows: <u>Carbolic Acid Poison</u> <u>Potably Intoxicated</u> (Duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds.	
9 BIRTHPLACE (State or country) <u>Ky.</u>		Contributory <u>Spinal Sclerosis</u> Secondary	
10 NAME OF FATHER <u>Wm. H. Brown</u>		(Signed) <u>Wm. H. Brown</u> , M. D.	
11 BIRTHPLACE OF FATHER (State or country) <u>La.</u>		<u>May 27<sup>th</sup></u> , 191 <u>4</u> . (Address) <u>Orange St.</u>	
12 MAIDEN NAME OF MOTHER <u>Gertrude E. Ball</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
13 BIRTHPLACE OF MOTHER (State or country) <u>Ky.</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. H. Brown</u> (Address) <u>Annapolis Jct. Md.</u>			
15 Filed <u>May 28<sup>th</sup></u> , 191 <u>4</u> <u>L. H. J. Haskins</u> REGISTRAR			
19 PLACE OF BURIAL OR REMOVAL <u>Spring Ridge Cemetery</u>		DATE OF BURIAL <u>June 2<sup>nd</sup></u> , 191 <u>4</u>	
20 UNDERTAKER <u>Fisher &amp; Phair</u>		ADDRESS <u>Laurel Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

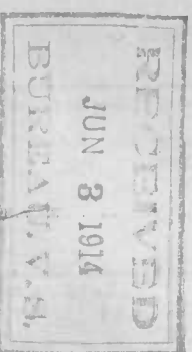
[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Interstitial heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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ly.

1 PLACE OF DEATH 4506  
 County A. A. Co  
 Village or City Near Laurel Md. (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward) 22  
 2 FULL NAME Mrs. Mary Brown

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female  
 4 COLOR OR RACE White  
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married  
 6 DATE OF BIRTH Mar. 18<sup>th</sup> 1829  
 (Month) (Day) (Year)  
 7 AGE 85 yrs. 2 mos. 1 ds. If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Germany

PARENTS  
 10 NAME OF FATHER Edward Vernon  
 11 BIRTHPLACE OF FATHER (State or country) Germany  
 12 MAIDEN NAME OF MOTHER Miss Vernon  
 13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob C. Brown  
 (Address) Laurel, Md.

15 Filed May 19, 1914 L. H. 214 Laurel  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1914, to May 19, 1914,  
 that I last saw her alive on May 19, 1914

and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
& Paralysis

Contributory Exhaustion  
 Secondary

(Signed) W. F. Taylor, M. D.  
May 20, 1914 (Address) Laurel Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,  
 If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Martinsburg W. Va. DATE OF BURIAL May 22, 1914

20 UNDERTAKER Geo. E. French ADDRESS Laurel Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

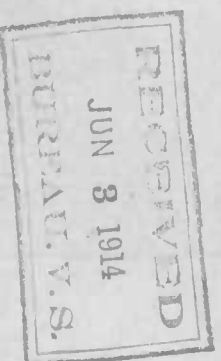
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Anne Arundel 4567

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

Village or City

Bristol

(No. ....)

St.; .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Brown

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR ORPHANED  
(Write the word)

Single

6 DATE OF BIRTH

May 27, 1914  
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds.

If LESS than  
1 day, .... hrs.  
OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

None

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Ind.

## PARENTS

10 NAME OF  
FATHER

Henry Brown

11 BIRTHPLACE  
OF FATHER  
(State or country)

Ind.

12 MAIDEN NAME  
OF MOTHER

Phoebe Sellman

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Brown

(Address)

Bristol, Ind.

15

Filed

May 27, 1914

A. H. Perrie  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Still born

May 27, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
not seen by a physician  
mother attended by midwife  
that I last saw him alive on May 27, 1914

and that death occurred on the date stated above, at .... m.

The CAUSE OF DEATH\* was as follows:

Still born

Contributory  
(Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed)

A. H. Perrie

, M. D.

May 27, 1914 (Address) McRendree, Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted,

If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Farm of Addison Owens

DATE OF BURIAL

May 27, 1914

20 UNDERTAKER

Buried by  
Thos. Sellman

ADDRESS

Bristol, Ind.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

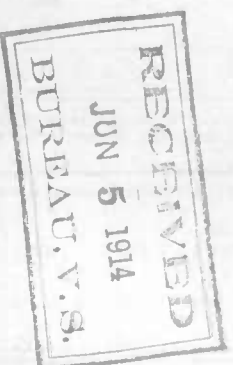
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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1 PLACE OF DEATH 4508

County Anne ArundelVillage or City South River

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

Registration Dist. No. 20

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME (Still born) Infant boy of Sengmore Collins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May 5, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?  
If LESS than 1 day, \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Sengmore Collins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Brown

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Collins(Address) South River Md

15 Filed May 5, 1914 John Collins REGISTRAR  
Durb.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8 o'clock, 1914, to not attended, 1914, that I last saw him alive on, 1914

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:

Unknown  
Still Born  
N.B. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) John Collins, M. D.  
May 5, 1914 (Address) South River Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL South River DATE OF BURIAL May 6, 1914

20 UNDERTAKER Thomas Collins ADDRESS South River Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

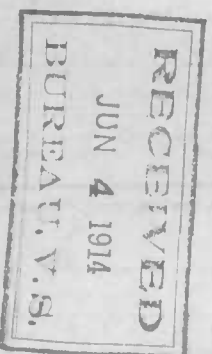
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**1 PLACE OF DEATH** 4500  
 County Anne Arundel  
 Village or City Crownsville State Hospital (No. 120) St. 1 Ward 2  
**2 FULL NAME** Hager Coster

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Female **4 COLOR OR RACE** Black **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)** Married

**6 DATE OF BIRTH** Unknown, 1838  
 (Month) (Day) (Year)

**7 AGE** 76 yrs. Unknown mos. Unknown ds. **If LESS than 1 day, hrs. OR min. ?**

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Housework  
 (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE** (State or country) Unknown

**PARENTS**  
**10 NAME OF FATHER** Isaac Camfer  
**11 BIRTHPLACE OF FATHER** (State or country) Maryland  
**12 MAIDEN NAME OF MOTHER** Unknown  
**13 BIRTHPLACE OF MOTHER** (State or country) Maryland

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Hospital  
 (Address) Records

**15** 5/8, 1944  
 Filed Dr. Joyce REGISTRAR  
Dr. Joyce

MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** May 8, 1944  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from** Feb. 25, 1944, to May 8, 1944.

that I last saw h. 22 alive on May 8, 1944.

and that death occurred on the date stated above, at 2 a m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

(Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory Chronic Coma  
 Secondary

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) Robert S. Smither M. D.  
May 8, 1944 (Address) Crownsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death 2 yrs. 10 mos. 10 ds. In the Unknown State Unknown yrs. Unknown mos. Unknown ds.

Where was disease contracted, Unknown

If not at place of death?

Former or usual residence Baltimore City

**19 PLACE OF BURIAL OR REMOVAL** Cambridge Dorchester Co  
Md.

**DATE OF BURIAL** 6/9, 1944

**20 UNDERTAKER** Danl. Easton

**ADDRESS** 916 Penna ave  
Baltimore Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

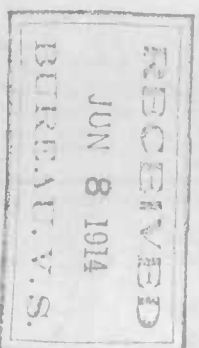
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1 PLACE OF DEATH County <u>A. A.</u>			4510			(154)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Brooklyn</u> (No. <u>532</u> , <u>Potomac ave</u> St.; ..... Ward)						Registered No. <u>25</u>			[It death occurred in a hospital or institution, give its NAME instead of street and number.]		
2 FULL NAME <u>Catherine V. A. Cropper</u>											
PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH					
3 SEX <u>Female</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>		18 DATE OF DEATH <u>May 21</u> , 191 <u>4</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>Nov 23</u> , 18 <u>42</u> (Month) (Day) (Year)		7 AGE <u>71</u> yrs. <u>5</u> mos. <u>28</u> ds. It LESS than 1 day, .... hrs. OR .... min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 15</u> , 191 <u>4</u> , to <u>Apr 21</u> , 191 <u>4</u> , that I last saw h <u>er</u> alive on <u>May 18</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2 A.</u> m. The CAUSE OF DEATH* was as follows: <u>General Debility &amp; Heart failure</u>							
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		<u>at home</u>									
9 BIRTHPLACE (State or country)		<u>Va</u>									
PARENTS	10 NAME OF FATHER		<u>Thos. Hartman</u>								
	11 BIRTHPLACE OF FATHER (State or country)		<u>Germany</u>								
	12 MAIDEN NAME OF MOTHER		<u>Mary E. Nighten</u>								
13 BIRTHPLACE OF MOTHER (State or country)		<u>Va</u>									
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary E. Canon</u> (Address) <u>532 Potomac ave</u>											
15 Filed <u>May 21</u> , 191 <u>4</u>		<u>Chas. H. Brooke</u> REGISTRAR									
19 PLACE OF BURIAL OR REMOVAL <u>Cedar Hill</u>						DATE OF BURIAL <u>May 24</u> , 191 <u>4</u>					
20 UNDERTAKER <u>Junkler &amp; Junkler</u>						ADDRESS <u>1739 E. Eager</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

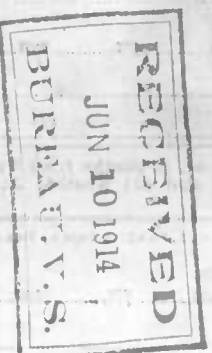
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*, *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

4511

County Anne ArundelVillage or City Cinnarville (No. State Hospital St.; Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Henry Lewis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Unknown, 1864  
(Month) (Day) (Year)

7 AGE 50 yrs. Unknown If LESS than 1 day, hrs. OR min. ?  
mos. ds.

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work House Servant  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE  
(State or country)Unknown

## 10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER  
(State or country)Unknown

## 12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER  
(State or country)Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address)

15

Filed

523

1914

17

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1913, to May 23, 1914.  
that I last saw him alive on May 23, 1914

and that death occurred on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH\* was as follows:

Chronic Interstitial Nephritis

Contributory Chronic Nephritis  
Secondary (Duration) 1 yrs. — mos. — ds.

(Signed) R. P. Winter, M. D.  
May 23, 1914 (Address) Crownsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. — mos. — ds. In the Unknown State — yrs. — mos. — ds.

Where was disease contracted, UnknownIf not at place of death? UnknownFormer or usual residence Baltimore City

## 19 PLACE OF BURIAL OR REMOVAL

Hospital Cemetery

## DATE OF BURIAL

May 25, 1914

## 20 UNDERTAKER

R. P. Winter

## ADDRESS

Waterbury

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

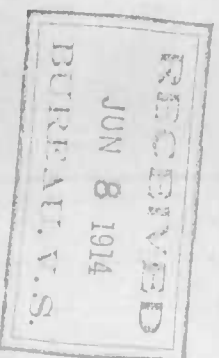
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Cancer*,

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4512

County a-a-Village or City Jones Md (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Day

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Aug - 1, 1913  
(Month) (Day) (Year)

7 AGE 9 4 If LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?  
\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Jones Md-

10 NAME OF FATHER Aaron Day

11 BIRTHPLACE OF FATHER (State or country) Arnolds Md

12 MAIDEN NAME OF MOTHER Florence Thomas

13 BIRTHPLACE OF MOTHER (State or country) Arnolds Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aaron Day(Address) Arnolds Md

15 Filed May 5, 1914 Jms Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 25, 1914, to May 3, 1914.

that I last saw him alive on May 3, 1914.

and that death occurred on the date stated above, at 1 A m.

The CAUSE OF DEATH\* was as follows:

Lobular Pneumonia(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 9 ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) R B Miller, M. D.

Apr 25, 1914 (Address) 28 Robert St

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Broad Creek Cmt DATE OF BURIAL 5-8, 1914

20 UNDERTAKER E H B Parker & Son ADDRESS 92 West St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

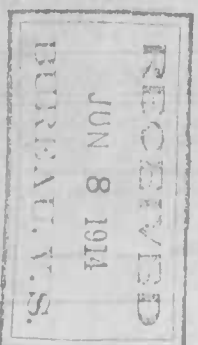
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH		4513		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>N.Y.</u>				Registration Dist. No. <u>24</u>	
Village or City <u>East Brooklyn</u>		(No. <u>1</u> )		St.; Ward)	
2 FULL NAME <u>(Dead Born) Garsinsky</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Dead Born</u>			
6 DATE OF BIRTH <u>May 3<sup>rd</sup>, 1914</u>					
7 AGE <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.		If LESS than 1 day, <u>0</u> hrs. <u>0</u> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>md</u>					
PARENTS	10 NAME OF FATHER <u>Vincent Garsinsky</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Frances Merlinger</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Vincent Garsinsky</u> (Address) <u>East Brooklyn, Md</u>					
15 FILED <u>May 3<sup>rd</sup>, 1914</u> <u>Thos. B. Norton</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 3<sup>rd</sup>, 1914</u>					
17 I HEREBY CERTIFY That I attended deceased from <u>May 3<sup>rd</sup>, 1914</u> to <u>May 3<sup>rd</sup>, 1914</u>					
that I last saw h. <u>May 3<sup>rd</sup>, 1914</u> alive on <u>May 3<sup>rd</sup>, 1914</u>					
and that death occurred on the date stated above, at <u>May 3<sup>rd</sup>, 1914</u> m.					
The CAUSE OF DEATH* was as follows: <u>Dead Born</u>					
(Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.					
Contributory Secondary					
(Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>Thos. B. Norton</u> , M. D. <u>May 3<sup>rd</sup>, 1914</u> (Address) <u>So. Baltimore Sta., Curtis Bay, Md.</u>					
*State the DISEASE CAUSING DEATH, or, if death from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>So. Baltimore Sta., Curtis Bay, Md.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>St. Stanislaus Cemetery</u>					
20 UNDERTAKER <u>M. Sadowsky</u>					
DATE OF BURIAL <u>May 4<sup>th</sup>, 1914</u>					
ADDRESS <u>Balto., Md</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



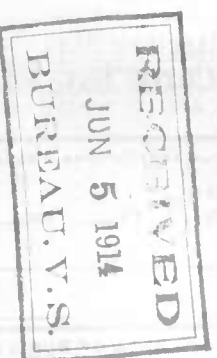
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4514

151

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty AARegistration Dist. No. 21Village or City Annapolis (No. Market Spce St.; 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Baby Graefe

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH

May 4, 1914  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day.....hrs.  
OR 4 min. ?  
..... yrs. .... mos. .... ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis Md

## PARENTS

10 NAME OF FATHER

George Graefe11 BIRTHPLACE OF FATHER  
(State or country)Balto Md

12 MAIDEN NAME OF MOTHER

Emily Burtis13 BIRTHPLACE OF MOTHER  
(State or country)Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Graefe

(Address)

Annapolis Md

15

Filed

May 5, 1914Jms Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 4, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 4, 1914, to May 4, 1914that I last saw him alive on May 4<sup>th</sup>, 1914and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:

Permatum Birth

(Duration) ..... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

J. Phoebe Purvis, M. D.May 5, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR CREMATION

DATE OF BURIAL

St. Mary's Cemetery May 5, 1914

20 UNDERTAKER

ADDRESS

Jas S. Taylor & Sons Annapolis

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

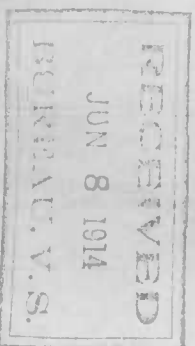
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH <u>4515</u>		(28)		STATE OF MARYLAND	
County <u>A. A. County</u>		CERTIFICATE OF DEATH			
Village or City <u>Annapolis Md</u>		(No. <u>19</u> <u>Obrian</u> <u>Alley</u> St. <u>3</u> Ward)		Registration Dist. No. <u>21</u>	
2 FULL NAME <u>Philip Green</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>May 24th</u> , 188 <u>8</u>		(Month) (Day) (Year)			
7 AGE <u>25</u> yrs. <u>4</u> mos. <u>23</u> ds.		It LESS than 1 day.....hrs. OR.....mo.?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Cook</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Annapolis Md</u>					
PARENTS	10 NAME OF FATHER <u>John H green</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>West river Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Caroline green</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Calvert County Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Caroline green</u> (Address) <u>34 North West st</u>					
15 Filed <u>May 19, 1914</u> <u>Mrs M. S. M. M. M.</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 17</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Apr. 15</u> , 191 <u>4</u> , to <u>May 17</u> , 191 <u>4</u> , that I last saw <u>him</u> alive on <u>May 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>10-30</u> m.					
The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u>					
(Duration) ..... yrs. <u>1</u> mos. <u>3</u> ds.					
Contributory (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds.					
(Signed) <u>Dr. R. B. Williams</u> , M. D. <u>May 18</u> , 191 <u>4</u> . (Address) <u>2 E. Calvert St.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>Brewer Hill</u>				DATE OF BURIAL <u>May 18</u> , 191 <u>4</u>	
20 UNDERTAKER <u>J. A. Adams</u>				ADDRESS <u>Annapolis</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

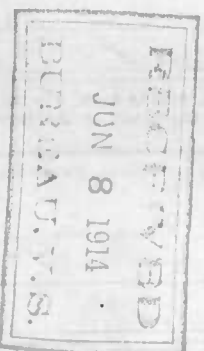
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1 PLACE OF DEATH 4516  
 County A # County  
 Village or City Annapolis Md, 9 obrian alley (No. 3 Ward) Registration Dist. No. 21  
 2 FULL NAME William green [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>	18 DATE OF DEATH <u>May 17</u> , 191 <u>4</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>April 11th</u> , 18 <u>74</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>April 20</u> , 191 <u>4</u> , to <u>May 17</u> , 191 <u>4</u> , that I last saw him alive on <u>May 17</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2 P</u> m.	
7 AGE <u>41</u> yrs. <u>1</u> mos. <u>7</u> ds. IF LESS than 1 day.....hrs. OR.....mo. ?			The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Waiter</u> (b) General nature of industry, business, or establishment in which employed (or employer)			(Duration) yrs. <u>2</u> mos. <u>-</u> ds. <u>Heart Failure</u>	
9 BIRTHPLACE (State or country) <u>Annapolis Md</u>			Contributory (Secondary) <u>Immediate</u> (Duration) yrs. .... mos. .... ds. (Signed) <u>Ambrose Garcia</u> , M. D. <u>5. 19</u> , 191 <u>4</u> (Address) <u>Annapolis Md</u>	
PARENTS	10 NAME OF FATHER <u>John H green</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
	11 BIRTHPLACE OF FATHER (State or country) <u>West River Md</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds. Where was disease contracted, If not at place of death?		
	12 MAIDEN NAME OF MOTHER <u>Caroline grose</u>	Former or usual residence.....		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Calvert County Md</u>	19 PLACE OF BURIAL OR REMOVAL <u>Brewer Cemetery</u> DATE OF BURIAL <u>May 19</u> , 191 <u>4</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Caroline green</u> (Address) <u>34 North West st</u>			20 UNDERTAKER <u>J. A Adams</u> ADDRESS <u>Annapolis</u>	
15 Filed <u>May 19</u> , 191 <u>4</u> <u>Jms Welch</u> REGISTRAR				

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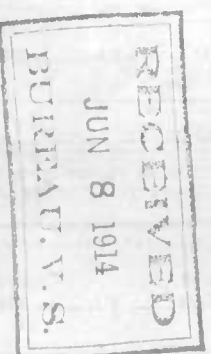
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*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*; *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Prince Georges</u>			Registration Dist. No. <u>26</u>	
Village or City <u>near Friendship</u> (No. <u>    </u> )			St. <u>    </u> Ward) <u>    </u>	
[It death occurred in a hospital or institution, give its NAME instead of street and number.]				
2 FULL NAME <u>Annanda Hall</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widowed</u> (Write the word)		
6 DATE OF BIRTH <u>Not known</u> , 18 <u>39</u> (Month) (Day) (Year)				
7 AGE <u>83</u> yrs. <u>Not known</u> mos. <u>    </u> ds. <u>    </u> min. ? If LESS than 1 day, hrs. <u>    </u> min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Dom no work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>in 15 years</u>				
9 BIRTHPLACE (State or country) <u>Unknown</u>				
PARENTS				
10 NAME OF FATHER <u>"</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm Creek</u> (Address) <u>Friendship</u>				
15 Filed <u>May 21</u> , 191 <u>4</u> <u>A. H. Perie</u> <u>Local</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 19</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>    </u> , 191 <u>    </u> , to <u>    </u> , 191 <u>    </u> , that I last saw h <u>    </u> alive on <u>    </u> , 191 <u>    </u> , and that death occurred on the date stated above, at <u>    </u> m. The CAUSE OF DEATH* was as follows: <u>I never saw this patient</u> <u>Cause of death seems to be</u> <u>last of many attacks of</u> <u>Hemiplegia</u> (Duration) <u>30</u> yrs. <u>    </u> mos. <u>    </u> ds. <u>Contributory</u> <u>Exhaustion</u> (Secondary) <u>    </u> (Duration) <u>    </u> yrs. <u>    </u> mos. <u>8</u> ds. (Signed) <u>Ampton Wilson</u> , M. D. <u>May 21</u> , 191 <u>4</u> (Address) <u>Friendship</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. In the State <u>    </u> yrs. <u>    </u> mos. <u>    </u> ds. Where was disease contracted, It not at place of death? Former or usual residence <u>    </u>				
19 PLACE OF BURIAL OR REMOVAL <u>M. Kendra Md</u>			DATE OF BURIAL <u>May 21</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Robt. J. Wood</u>			ADDRESS <u>Friendship Ind</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.				

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

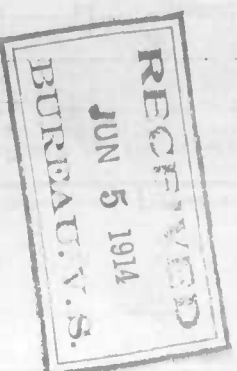
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative *jealunf*ness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4518

County

Anne Arundel

Village or City

Patient

(No.

St.

Ward)

2 FULL NAME

Richard Hall

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

22

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDDED,  
OR DIVORCED  
(Write the word)

single

6 DATE OF BIRTH

9 5

3 -

1999

(Month)

(Day)

(Year)

7 AGE

15

yrs.

8

mos.

ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Director of Cheltenham Industrial School for past two years

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Andrew Hall

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary M. Cullen

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary M. Cullen

(Address)

Patient - Mr. Hall

15

Filed

May 3rd 1914

L. H. Haskins

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5

3

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 17, 1914, to April 30th, 1914.

that I last saw him alive on April 30, 1914.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis

Patient - under my care for only two weeks +  
cannot say (Duration) yrs. mos. ds.

Contributory  
Secondary

cannot state (Duration) yrs. mos. ds.

(Signed)

R. H. Hammond

M. D.

May 3, 1914 (Address) Jesup Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland Cemetery

May 4, 1914

20 UNDERTAKER

ADDRESS

Patient - Mr. Hall

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

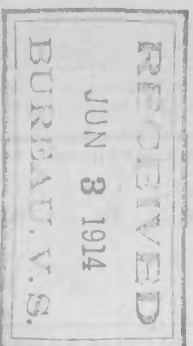
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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' PLACE OF DEATH 4519

County Anna Arundel.Village or City Annapolis. (No. 32 Market Space. St. / Ward)Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAME Emma Wilhelmina Hantske.

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Female <sup>4</sup> COLOR OR RACE White <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Married.  
(Write the word)

<sup>6</sup> DATE OF BIRTH December 26, 1846  
(Month) (Day) (Year)

<sup>7</sup> AGE 67 yrs. 4 mos. 13 ds. It LESS than 1 day, hrs. OR min. ?

<sup>8</sup> OCCUPATION  
(a) Trade, profession, or particular kind of work House-wife.  
(b) General nature of industry, business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE (State or country) Germany.

**PARENTS**  
<sup>10</sup> NAME OF FATHER Walther, Charles  
<sup>11</sup> BIRTHPLACE OF FATHER (State or country) Germany.  
<sup>12</sup> MAIDEN NAME OF MOTHER Bosse  
<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) Germany.

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) M. A. Hantske  
(Address) Annapolis, Md.

<sup>15</sup> Filed May 11, 1914 Wm S Welch  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH 18 May 9th, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from April 1st, 1914 to May 9th, 1914

that I last saw her alive on May 8th, 1914

and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH\* was as follows:

Arterio sclerosis (general)

(Duration) ? yrs. ? mos. ? ds.

Contributory Cardio-renal Asthma.  
Secondary

(Duration) 1 yrs. 9 mos. 9 ds.

(Signed) J. H. Hantske M. D.  
May 11, 1914 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?

Former or usual residence

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Annapolis, Cedar Bluff DATE OF BURIAL May 11, 1914

<sup>20</sup> UNDERTAKER J. S. Taylor. ADDRESS Long Annapolis

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

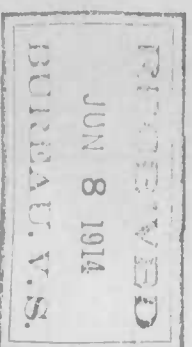
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4520  
County Anne Arundel

Village or City Birdsville (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 20

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME (Still born) child of Preston Harrison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX unknown 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May 9, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Preston Harrison

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Smith

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace Smith

(Address) Birdsville Md

15 Filed May 11, 1914 John Callinan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from One visit, 1914, to May 9, 1914.

that I last saw him alive on \_\_\_\_\_, 1914.

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH\* was as follows:

In uterine gestation 3 month  
mother was frightened

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) John Callinan, M. D.

May 11, 1914 (Address) Birdsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Birdsville May 9, 1914

20 UNDERTAKER ADDRESS

Preston Harrison Birdsville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

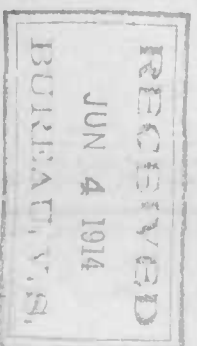
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4521  
 County Anne Arundel  
 Villages or City Brownwood (3<sup>rd</sup> Dist) (No. 151) St.; Ward \_\_\_\_\_  
 2 FULL NAME May Heuson  
 Registration Dist. No. 2.1 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 23, 1914  
 (Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 1 LESS than 1 day, 9 hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Brownwood Dist Md

PARENTS

10 NAME OF FATHER Charles Colbert

11 BIRTHPLACE OF FATHER (State or country) Brownwood Dist Md

12 MAIDEN NAME OF MOTHER Helena Heuson

13 BIRTHPLACE OF MOTHER (State or country) Brownwood Dist Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Elyah Heuson  
 (Address) Grand Fisher

15 Filed May 24, 1914 James Welch  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1914, to \_\_\_\_\_, 191\_\_\_\_, that I last saw her alive on May 23, 1914, and that death occurred on the date stated above, at 5 P m.  
 The CAUSE OF DEATH\* was as follows:  
Collapse of lungs  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
 Secondary \_\_\_\_\_

(Signed) Ambrose Garcia, M. D.  
524, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted, if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Broad Neck DATE OF BURIAL May 24, 1914

20 UNDERTAKER Samuel Allen ADDRESS 32 Northview

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

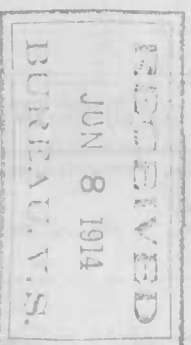
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scnile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County

Anne Arundel

Village or City

Brooklyn (No. Humphreys Station St. Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

285

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

John W. O'Hines

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,

MARRIED

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

1834

(Month)

(Day)

(Year)

7 AGE

80

yrs.

mos.

ds.

if LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md

10 NAME OF FATHER

Geo. Hines

11 BIRTHPLACE OF FATHER (State or country)

Md

12 MAIDEN NAME OF MOTHER

Catherine Ross

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Hines

(Address)

Humphreys Md

15

Filed

May 28, 1914 Chas O'Brook

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

27<sup>th</sup>, 1914

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

February 16<sup>th</sup>, 1914, to May 27<sup>th</sup>, 1914,that I last saw him alive on May 26<sup>th</sup>, 1914,

and that death occurred on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. 3 mos. 11 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Harry Weibel M.D.

May 28<sup>th</sup>, 1914 (Address) 1217 Lawrence St. Balto.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Funerary Branch

DATE OF BURIAL

May 29, 1914

20 UNDERTAKER

John H. Ladd

ADDRESS

1430 Hill St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUN 10 1914  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4523

County Anne ArundelVillage or City Robinson, (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME

Annie JacksonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

June 20, 1900  
(Month) (Day) (Year)

7 AGE

13 yrs. 10 mos. 20 ds. 11 LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Anne Arundel Co. Md.

10 NAME OF FATHER

Joseph Jackson

11 BIRTHPLACE OF FATHER (State or country)

Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER

Fannie Carroll

13 BIRTHPLACE OF MOTHER (State or country)

Anne Arundel Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis Jackson(Address) Robinson Md.

15

Filed May 10, 1914 J. S. Bellingsley

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 10, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
Signed by sub-registrar, no physician was attending.  
(Duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) James S. Bellingsley, M. D.May 10, 1914 (Address) Elvaton Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lower Neck Burial Ground May 12, 1914

20 UNDERTAKER

ADDRESS

Denny & Armstrong Co. Balto. Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



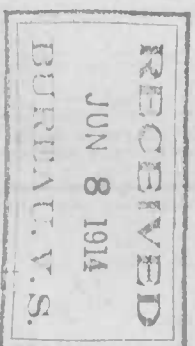
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septiche- mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio- lent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac- cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 4524  
 County Anne Arundel  
 Village or City Indeavour Heights (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
**2 FULL NAME** John Jasek

STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 23

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Male **4 COLOR OR RACE** White **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single  
 (Write the word)

**6 DATE OF BIRTH** July, 1910  
 (Month) (Day) (Year)

**7 AGE** 3 yrs. 11 mos. ds. OR min. ?  
 It LESS than 1 day, \_\_\_\_\_ hrs.

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE** (State or country) Baltimore

**PARENTS**  
**10 NAME OF FATHER** Michael Jasek  
**11 BIRTHPLACE OF FATHER** (State or country) Austria  
**12 MAIDEN NAME OF MOTHER** Eleanora Granda  
**13 BIRTHPLACE OF MOTHER** (State or country) Russia

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Michael Jasek  
 (Address) Baltimore Md

**15** May 27, 1914 C. R. Winkler  
 Filed \_\_\_\_\_ REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** May 27, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
on May 27, 1914, to buried, 1914

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 1914

and that death occurred on the date stated above, at not known

The CAUSE OF DEATH\* was as follows:

Traveled from home - was lost from 8 o'clock  
2 m. May 26 until 4 P.M. May 27  
and died from exposure to heat  
from (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**Contributory**  
 Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) C. R. Winkler, M. D.  
May 27, 1914 (Address) Hanover Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** St. Stanislaus Cemetery **DATE OF BURIAL** May 28, 1914

**20 UNDERTAKER** Baltimore Md **ADDRESS** Stephen Kalkowski Baltimore Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

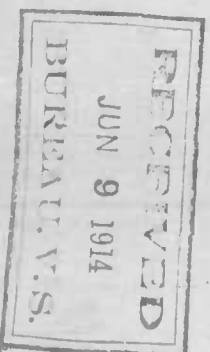
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>A. A. Co.</u> <u>4525</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>St Margaret</u> (No. ....) St; .... Ward)		Registered No. <u>21</u>	
2 FULL NAME <u>Adelaide Johns</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>May 2</u> , 18 <u>69</u> (Month) (Day) (Year)			
7 AGE <u>45</u> yrs. — mos. <u>14</u> ds.		If LESS than 1 day, .... hrs. OR .... min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) .....			
9 BIRTHPLACE (State or country) <u>A. A. Co. Md.</u>			
PARENTS	10 NAME OF FATHER <u>Edrick Johns</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		
	12 MAIDEN NAME OF MOTHER <u>Louisa Taylor</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Allen Chandler</u> (Address) <u>St Margaret Md.</u>			
15 Filed <u>May 16</u> , 191 <u>4</u> <u>Jms Welch</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 15</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw him ..... alive on ..... 191..... and that death occurred on the date stated above, at ..... m. The CAUSE OF DEATH* was as follows: <u>Heart Disease</u> (Duration) ..... yrs. .... mos. <u>30 min.</u> cs.			
Contributory (Secondary) .....			
(Signed) <u>J. D. Redout</u> , M. D. <u>May 16</u> , 191 <u>4</u> (Address) <u>St Margaret Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? .....			
Former or usual residence .....			
19 PLACE OF BURIAL OR REMOVAL <u>Broad Neck Cemts</u>		DATE OF BURIAL <u>May 17</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Jas J Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

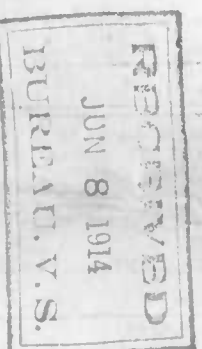
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automotive factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not fully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>A. A. Co</u>		4526	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Best Gate</u> (No. <u>120</u> )		Registration Dist. No. <u>21</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Charles Johnson</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>		
6 DATE OF BIRTH <u>June 15</u> , 18 <u>56</u> (Month) (Day) (Year)				
7 AGE <u>57</u> yrs. <u>11</u> mos. <u>3</u> ds.		It LESS than 1 day.....hrs. OR.....min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Labour</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Unknown</u>				
PARENTS				
10 NAME OF FATHER <u>Unknown</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William L. Johnson</u> (Address) <u>Best Gate A. A. Co 120</u>				
15 Filed <u>May 20</u> , 191 <u>4</u> <u>Jms Welch</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 18th</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>April 7th</u> , 191 <u>4</u> , to <u>May 18th</u> , 191 <u>4</u> , that I last saw him alive on <u>May 17th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11 A</u> m.				
The CAUSE OF DEATH* was as follows: <u>Nephritis Chronic</u> <u>Exhaustion</u> <u>Heart Failure</u> (Duration) ..... yrs. .... mos. .... ds.				
Contributory Secondary <u>Several years gradual</u> (Signed) <u>John Pielont</u> , M. D. <u>May 19th</u> 191 <u>4</u> (Address) <u>Annapolis</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence.....				
19 PLACE OF BURIAL OR REMOVAL <u>St. John's Cemetery</u>			DATE OF BURIAL <u>May 21st</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Samuel Allen</u>			ADDRESS <u>32 N. W. St</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

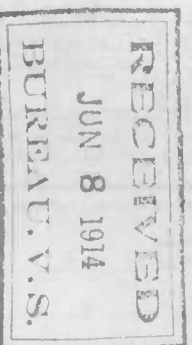
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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 4527  
County Prince Georges

Village or City Friendship (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Jones (Still - Born)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 6, 1914  
(Month) (Day) (Year)

7 AGE Still born at about sixth month If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Wallace Jones

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Katie Jacks

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Jones

(Address) Friendship

15 Filed May 6, 1914 A. N. Perrie  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Not Known, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

No motion has been felt for about 3 WKS

Cause not known (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_

(Signed) Campton Wilson, M. D.  
May 6, 1914 (Address) Friendship Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Friendship DATE OF BURIAL May 6, 1914

20 UNDERTAKER Carried by Wesley Conlee ADDRESS Friendship Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

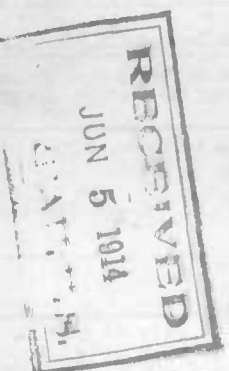
[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

4528

County Anne Arundel
 4 STATE OF MARYLAND  
 CERTIFICATE OF DEATH
Registration Dist. No. 20Village or City Galloways (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)
 [If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]
2 FULL NAME Cigores Kirby

## PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
6 DATE OF BIRTH February - 1911  
(Month) (Day) (Year)7 AGE 3 yrs. 2 mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?
 8 OCCUPATION  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) None
9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Thomas Kirby11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Annie Watkins13 BIRTHPLACE OF MOTHER (State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Kirby(Address) Galloways Md15 Filed May 13, 1914 Machine Cawood

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 12, 1914  
(Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from May 5, 1914, to May 10, 1914,  
 that I last saw her alive on May 10, 1914,
and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH\* was as follows:

Remittent fever

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
SecondaryMalaria

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Machine Cawood, M. D.May 14, 1914. (Address) West River Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Daniel Star Cemetery May 13, 1914

20 UNDERTAKER

ADDRESS

Hardesty & Hunt Galloways



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

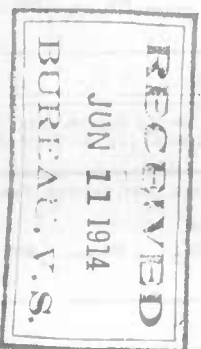
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH

4529

CP

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County

At Co Md

Registration Dist. No.

21

Village or City

Annapolis (No. 90 blay

St.

3<sup>rd</sup> Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bessie J Kirby

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

col

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

Unknown

7 AGE

17 Months

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Annapolis

## PARENTS

10 NAME OF FATHER

Wm Kirby

11 BIRTHPLACE OF FATHER

(State or country)

At Co Md

12 MAIDEN NAME OF MOTHER

Mary Wenn

13 BIRTHPLACE OF MOTHER

(State or country)

At Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Wenn

(Address)

Annapolis Md

15

Filed

May 24, 1914 Wm S Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 22<sup>nd</sup>, 1914

17

I HEREBY CERTIFY, That I attended deceased from

May 13<sup>th</sup>, 1914, to May 22<sup>nd</sup>, 1914that I last saw her alive on May 22<sup>nd</sup>, 1914and that death occurred on the date stated above, at 9<sup>PM</sup> m.

The CAUSE OF DEATH\* was as follows:

Dentition  
Meningitis  
Several days (Duration) yrs. mos. ds.  
Contributory Exhaustion  
Secondary Gradual  
(Signed) John A. Donohue, M. D.  
May 23<sup>rd</sup>, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brown Hill Cmt

May 24, 1914

20 UNDERTAKER

ADDRESS

Geo S Gayler, Son

Annapolis Md

If more blanks are needed, address State Registrar, C. E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

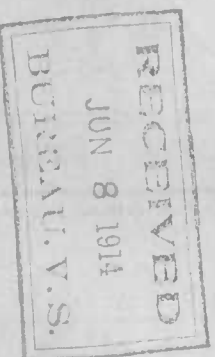
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4530  
 County Anne Arundel  
 Village or City Brooklyn (No. 535 Carroll St.; Ward)  
 Registered No. 25  
 2 FULL NAME William Glenward Langford  
 ([If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single  
 6 DATE OF BIRTH June 8th, 1913  
 (Month) (Day) (Year)  
 7 AGE 11 yrs. 5 mos. 5 ds. If LESS than 1 day, — hrs. OR — min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. —

(b) General nature of industry, business, or establishment in which employed (or employer) —

## 9 BIRTHPLACE (State or country)

Baltimore Md.

## 10 NAME OF FATHER

Carl Langford

## 11 BIRTHPLACE OF FATHER (State or country)

Indiana U.S.A.

## 12 MAIDEN NAME OF MOTHER

Fannie Potee

## 13 BIRTHPLACE OF MOTHER (State or country)

Brooklyn W.D. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. James M. Maunus

(Address)

537 Carroll St. Brooklyn Md.

## 15

Filed

May 16, 1914 Chas. H. Brown

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

May 13th, 1914  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

March 15th, 1914 to May 13th, 1914that I last saw him alive on May 13th, 1914and that death occurred on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH\* was as follows:

Marasmus(Duration) 2 yrs. — mos. — ds.

## Contributory (Secondary)

Convulsions(Duration) — yrs. — mos. 3 hours

(Signed)

Harry HeibelMay 13th, 1914 (Address) 274 Anson St. Balto. Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. Olivet CemeteryMay 14, 1914

## 20 UNDERTAKER

## ADDRESS

Armstrong Denny Co715 Light St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

4531

County

A. A.

Village or City

Clarkes

(No. ....)

Registration Dist. No.

22

St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lillie Eudora Marks

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *single*  
(Write the word)

6 DATE OF BIRTH *April 28, 1868*  
(Month) (Day) (Year)

7 AGE *46* yrs. *0* mos. *8* ds. If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) *Maryland*

10 NAME OF FATHER *Richard Marks*

11 BIRTHPLACE OF FATHER (State or country) *England*

12 MAIDEN NAME OF MOTHER *Jane Mitchell*

13 BIRTHPLACE OF MOTHER (State or country) *England*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE:

(Informant) *Hesterde Taylor*

(Address) *Severn P. O. Md.*

15 Filed *May 9th*, 191*4* *Holiday Ashaw* REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 6th*, 191*4*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *April 8*, 191*4*, to *May 4*, 191*4*,  
that I last saw her alive on *May 4*, 191*4*

and that death occurred on the date stated above, at *12:15* m.

The CAUSE OF DEATH\* was as follows:

*Pulmonary Tuberculosis*

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) *O. M. Chenevix*, M. D.  
*May 7*, 191*4* (Address) *Odenton Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL *Odenton Md.* DATE OF BURIAL *May 9*, 191*4*

20 UNDERTAKER *Wm. Cook* ADDRESS *Baltimore*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

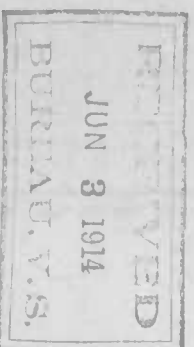
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCELERATED, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **4532**  
 County Anne Arundel  
 Village or City Shady Side (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Matthews

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)

6 DATE OF BIRTH May 23, 1914  
 (Month) (Day) (Year)

7 AGE \_\_\_\_\_ It LESS than 1 day, 6 hrs. OR \_\_\_\_\_ min. ?  
 0 yrs. 0 mos. 0 ds.

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

## PARENTS

10 NAME OF FATHER Thomas Matthews

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Queenie Brown

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Stumme  
 (Address) Shady Side

15 Filed May 23, 1914 Geo. T. Dent  
Deft Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from No Physician 191... to 191...  
 that I last saw him alive on in attendance 191...

and that death occurred on the date stated above, at 8 P m.  
 The CAUSE OF DEATH\* was as follows:

Congenital malformation of heart  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Geo. T. Dent M. D.  
May 23, 1914 (Address) Chicheston

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St Pauls Cemetery DATE OF BURIAL May 24, 1914

20 UNDERTAKER Richard Scott ADDRESS Shady Side

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

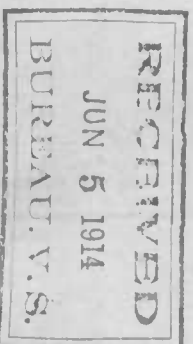
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative deathfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma. Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Huntton," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4533

County

Anne Arundel

Village or City

Near Lake Shom P.O. 3<sup>rd</sup> District A. & C.

2 FULL NAME

William, Marzynski

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

about 42

yrs.

mos.

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

at the death of "Pickering" in firm of Mr. O'Connor

9 BIRTHPLACE

(State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Skibinski

(Address)

2219 Choptank St. Balto

15

Filed

May 26, 1914

J. S. Beilingler

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 26 -

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

about

191

and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH\* was as follows:

Accidently drowned &amp; killed by falling head first in a well

Instantaneously

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Helville S. Dunlap J. P. Adams

Census

May 26, 1914

(Address)

2219 Choptank St. Balto

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Balls City

May 27, 1914

20 UNDERTAKER

ADDRESS

Robert J. Turner

Baltimore Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

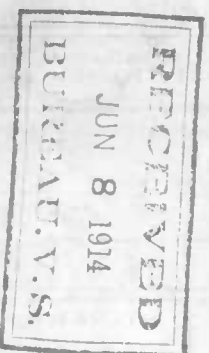
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Cloth engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Junction," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4534

County

a a

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

25

Village or City

Brooklyn

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wm Myers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Don't know

(Month)

(Day)

(Year)

7 AGE

26

yrs.

mos.

ds.

If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Thos. Myers

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Kaiser Armstrong

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Follet

(Address)

Brooklyn

15

Filed

May 22, 1914 Chas. O. Brooks

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 22, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_.

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Accidental Drowning

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

James H. Hawley  
May 23, 1914 (Address) Brooklyn

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

In the

State

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

Where was disease contracted, If out at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arcadia

May 24, 1914

20 UNDERTAKER

ADDRESS

Armstrong &amp; Co 1 Balto

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 10 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Anne Arundel  
3<sup>d</sup> Eden District  
 Village or City (No. .... St.; .... Ward)

4535

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

David Nichols

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown (Month) (Day) (Year)

7 AGE About 23 yrs. — mos. — ds. It LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Day Laborer (b) General nature of industry, business, or establishment in which employed (or employer) common labor

9 BIRTHPLACE (State or country) Philadelphia Pa

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry A. Barford

(Address) Clinton Md.

15 Filed May 27, 1914 J. S. Bellinger REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191..... that I last saw him alive on ..... 191.....

and that death occurred on the date stated above, at ..... m.  
 The CAUSE OF DEATH\* was as follows:—

Was in swimming tub when of storm  
and 3<sup>d</sup> of Oct. 4. and was  
accidentally drowned. (Suffered Cramp)  
a few moments. (Duration) ..... yrs. .... mos. .... ds.

Contributory (Secondary) None

(Signed) Helene S. Dwyer J.P. Acting Coroner M. D.  
 ..... 191..... (Address) Clinton a a c Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL on farm of Mr. Barford DATE OF BURIAL May 31, 1914  
in 3<sup>d</sup> of Oct. 4

20 UNDERTAKER None ADDRESS None



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

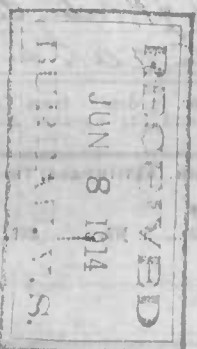
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*oma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic relapsing heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Tnition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <b>4536</b>		STATE OF MARYLAND <b>(120)</b> CERTIFICATE OF DEATH	
County <b>Anne Arundel</b>		Registration Dist. No. <b>26</b>	
Village or City <b>Churchton</b> (No. _____)		St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <b>Richard Offer</b>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <b>Male</b>	4 COLOR OR RACE <b>Col.</b>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Married</b> (Write the word)	
6 DATE OF BIRTH <b>Unknown</b> , 1861 (Month) (Day) (Year)			
7 AGE <b>53</b> yrs. <b>Unknown</b> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <b>Dyeingman</b> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <b>Maryland</b>			
PARENTS			
10 NAME OF FATHER <b>Thomas Offer</b>			
11 BIRTHPLACE OF FATHER (State or country) <b>Maryland</b>			
12 MAIDEN NAME OF MOTHER <b>Selina Blunt</b>			
13 BIRTHPLACE OF MOTHER (State or country) <b>Maryland</b>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <b>Louis Gross</b> (Address) <b>Churchton, Ind.</b>			
15 Filed <b>May 20, 1914</b> <b>Geo. T. Dent</b> REGISTRAR <b>Schultz Local</b>			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <b>May 20, 1914</b> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <b>Jan 1, 1914</b> , to <b>May 19, 1914</b> , that I last saw him alive on <b>May 19, 1914</b> , and that death occurred on the date stated above, at <b>8 A. M.</b>			
The CAUSE OF DEATH* was as follows: <b>Chronic Bright's disease</b>			
(Duration) <b>0</b> yrs. <b>8</b> mos. ____ ds.			
Contributory (Secondary)			
(Signed) <b>Geo. T. Dent</b> , M. D. <b>May 20, 1914</b> (Address) <b>Churchton, Ind.</b>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)			
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.			
Where was disease contracted, If not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <b>Seale Cemetery</b>		DATE OF BURIAL <b>May 21, 1914</b>	
20 UNDERTAKER <b>A. L. Glover</b>		ADDRESS <b>Sudley, Ind.</b>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

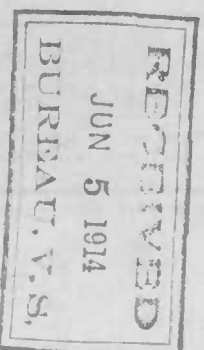
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4537

County

Anne Arundel

Village or City

Bristol

(No.

Registration Dist. No.

24

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James Edward Burns

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

August 20, 1913  
(Month) (Day) (Year)

7 AGE

yrs. 8 mos. 28 ds.

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)

Maryland

## PARENTS

10 NAME OF FATHER

Oliver Turner

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Florence Owens

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oliver Turner

(Address)

Bristol Md

15

Filed May 20, 1914

J. H. Perrie  
Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 19, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

2 o'clock to 2, 1914  
that I saw him alive on  
2 o'clock to 2, 1914

and that death occurred on the date stated above, at 12 A. m.

The CAUSE OF DEATH\* was as follows:

If then had an abscess on  
its leg which I opened  
any further cause of death I  
do not know (Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Maclean Gawood, M. D.

May 19, 1914 (Address) West River, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,  
or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Waller's Chapel

May 20, 1914

20 UNDERTAKER

ADDRESS

Wm O. Welch

Bristol, Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

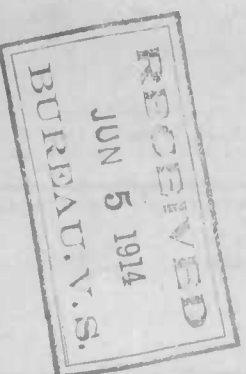
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name of organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4538

189

STATE OF MARYLAND  
CERTIFICATE OF DEATHCounty Anne ArundelRegistration Dist. No. 20Village or City Bayards (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Anna Belle Parker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH September 12, 1897  
(Month) (Day) (Year)

7 AGE 16 yrs. 7 mos. 25 ds. OR 16 yrs. 7 mos. 25 ds. If LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work House girl  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Fred Parker

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Tyler

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Parker(Address) Bayards, Md.

15 Filed May 8, 1914 Maclean Cawood and  
exp. local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1914, to May 7, 1914, that I last saw her alive on May 6, 1914

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Unknown, Temperature 105-9/5  
Pulse 5-8 & Strong. I could not  
make a diagnosis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

Contributory Unknown  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Maclean Cawood, M. D.May 8, 1914. (Address) West River, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Adam Chapel DATE OF BURIAL May 8, 1914

20 UNDERTAKER John Thomas ADDRESS York, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

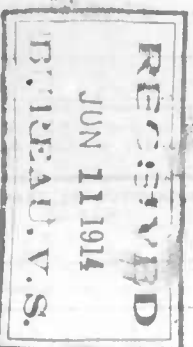
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis" etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>A. A. Co.</u>		4539		78		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Annapolis Md.</u> (No. <u>52</u> , <u>Pleasant</u> St.; <u>3</u> Ward)		Registration Dist. No. <u>21</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
2 FULL NAME <u>Bertha Peterson</u>							
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)					
6 DATE OF BIRTH <u>June 25</u> , 18 <u>95</u> (Month) (Day) (Year)							
7 AGE <u>18</u> yrs. <u>10</u> mos. <u>25</u> ds. If LESS than 1 day, .... hrs. OR .... min. ?							
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Domestic</u> (b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country) <u>Annapolis, Md.</u>							
PARENTS	10 NAME OF FATHER <u>John Peterson</u>						
	11 BIRTHPLACE OF FATHER (State or country) <u>South River, A. A. Co.</u>						
	12 MAIDEN NAME OF MOTHER <u>Luciel Ayers</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Prince George Co.</u>							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Luciel Peterson mother</u> (Address) <u>52 Pleasant St.</u>							
15 Filed <u>May 23</u> , 191 <u>4</u> <u>Chas. Welch</u> REGISTRAR							
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>May 20</u> , 191 <u>4</u> (Month) (Day) (Year)							
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 14</u> , 191 <u>3</u> , to <u>May 19</u> , 191 <u>4</u> . that I last saw her alive on <u>May 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4:45 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> <u>Heart Failure</u> (Duration) <u>8</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory <u>Impediment</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>Ambridge Davis</u> , M. D. <u>5.22</u> , 191 <u>4</u> (Address) <u>Annapolis, Md.</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL <u>Brewer Hill Cemetery</u>				DATE OF BURIAL <u>May 24</u> , 191 <u>4</u>			
20 UNDERTAKER <u>Samuel Allen</u>				ADDRESS <u>32. N. W. St.</u>			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

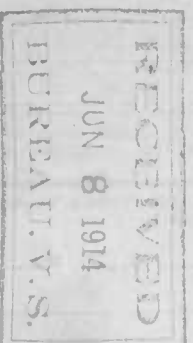
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4540

County AA Co. Md.STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Annapolis (No. 96, Dock St. St.; 1 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. Joseph T. Puckett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH February 6, 1842  
(Month) (Day) (Year)

7 AGE 72 yrs. 2 mos. 28 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Plasterer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Annapolis Md.

PARENTS  
10 NAME OF FATHER Charles E. Puckett  
11 BIRTHPLACE OF FATHER (State or country) Richmond Va.  
12 MAIDEN NAME OF MOTHER Margaret Podd  
13 BIRTHPLACE OF MOTHER (State or country) Baltimore Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. Johanna Puckett  
(Address) 96 Dock Street

15 Filed May 5, 1914 Jms Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1914, to May 3, 1914.

that I last saw him alive on May 3, 1914.

and that death occurred on the date stated above, at 7:15 m.

The CAUSE OF DEATH\* was as follows:  
Bright's Disease

(Duration) 4 yrs. 4 mos. 4 ds.

Contributory  
Secondary

(Signed) J. L. Joyce, M. D.  
May 6, 1914 (Address) Annapolis

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 72 yrs. 2 mos. 28 ds. In the State 72 yrs. 2 mos. 28 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Annes Cemetery DATE OF BURIAL May 6, 1914

20 UNDERTAKER Jas J Taylor Sons ADDRESS Annapolis Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

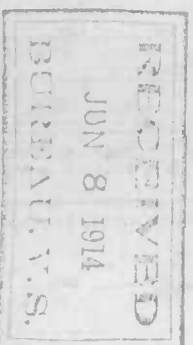
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4541

County

A. A.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

21

Village or City

Pimopolis

(No.

Collage Ave

St.;

1 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James H. Ray

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

6 DATE OF BIRTH

Jan 1

(Month)

(Day)

1843  
(Year)

7 AGE

72 yrs.

4 mos.

9 ds.

11 LESS than  
1 day, ..... hrs.  
OR ..... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Holland

## PARENTS

10 NAME OF FATHER

James H. Ray

11 BIRTHPLACE OF FATHER  
(State or country)

Holland

12 MAIDEN NAME OF MOTHER

Mary Rosseler

13 BIRTHPLACE OF MOTHER  
(State or country)

Texas

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert Ray

(Address)

21 S. Travel Academy  
Annapolis, Md.

15

Filed

May 10, 1914

Jms Welch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

9th

1914  
(Year)

(Month)

(Day)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 4th

1914, to

May 9th

1914.

that I last saw him alive on May 9th, 1914.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(Duration) several yrs. mos. ds.

Contributory  
Secondary

Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed)

Chas. Davis, M. D.

May 10, 1914

(Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

It not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

National Cem

May 10, 1914

20 UNDERTAKER

ADDRESS

Jas S. Ray &amp; Sons

Annapolis, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

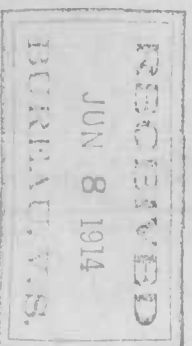
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## HEALTH DEPARTMENT—CITY OF BALTIMORE

4542

## CERTIFICATE OF DEATH.

5

## 1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

## 2-FULL NAME

(Residence in Baltimore: No.

St.; ..... yrs., ..... mos. .... ds.)

## PERSONAL AND STATISTICAL PARTICULARS.

## 3-SEX.

male

## 4-COLOR OR RACE,

Black

5-SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED,  
(Write the word.)

## 6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

## 7-AGE,

32

yrs. .... mos. .... ds.

If LESS than 1 day.

....hrs. or....min.

## 8-OCCUPATION:

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

Day Laborer

9-BIRTHPLACE,  
(State or Country),

Maryland.

## PARENTS.

## 10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER  
(State or Country),

## 12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER  
(State or Country),

## 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

## 15-

Filed

May 30<sup>th</sup> 1914

191

J. B. Hoffman M.D.

Registrar.

## MEDICAL CERTIFICATE OF DEATH.

## 16-DATE OF DEATH

May

(Month)

30<sup>th</sup>

(Day)

1914

(Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25<sup>th</sup> 1914, to May 30<sup>th</sup> 1914, that I saw him alive on May 30<sup>th</sup> 1914, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH\* was as follows:

Smallpox

CONTRIBUTORY  
(Secondary)

(Signed)

May 30, 1914

Thos. R. Richardson M. D.  
(Address) Quarantine Hospital

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

422 Newmarket St. Baltimore

## 19-PLACE OF BURIAL OR REMOVAL,

## DATE OF BURIAL,

Quarantine Cemetery

May 31, 1914

## 20-UNDERTAKER

## ADDRESS

Employee of Hospital

MARGIN RESERVED FOR BINDING

WHEN INK, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

# Remarks

RECEIVED

JUN 5 1914

BUREAU, V.S.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Intention," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL, septicæmia," "PUERPERAL, peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner: Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

4543

County

Anne Arundel

Village or City

Patuxent

(No.

Sanders

St.; Ward)

Registration Dist. No.

22

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 26, 1914

(Month) (Day) (Year)

7 AGE

yrs. mos. ds. OR min. ?

If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

William Sanders

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Laura Barnes

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Barnes

(Address)

Patuxent

15

Filed

May 27<sup>th</sup>, 1914 L. H. D. Itashup Local REGISTRARSTATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 26, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on Still Born, 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

R. H. Hammond, M. D.  
5227 1914 (Address) Jessup Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lamb Hill Burial Ground

May 27<sup>th</sup>, 1914

20 UNDERTAKER

ADDRESS

Patuxent



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 3 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <i>C. A.</i>		4544		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>C. A.</i>		Village or City <i>So Balto.</i>		Registration Dist. No. <i>24</i>	
		(No. <i>22</i> Hazel <i>91</i> )		St.; Ward)	
2 FULL NAME		<i>Sylvia Schneider</i>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Infant</i> (Write the word)			
6 DATE OF BIRTH <i>Dec. 30<sup>th</sup>, 1910</i> (Month) (Day) (Year)		7 AGE <i>3 yrs. 5 mos. 24 ds.</i> If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<i>Infant</i>			
9 BIRTHPLACE (State or country)		<i>So Balto.</i>			
PARENTS	10 NAME OF FATHER	<i>Frank Schneider</i>			
	11 BIRTHPLACE OF FATHER (State or country)	<i>Bohemian</i>			
	12 MAIDEN NAME OF MOTHER	<i>Antonette Franoe</i>			
	13 BIRTHPLACE OF MOTHER (State or country)	<i>Bohemia</i>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Frank Schneider</i> (Address) <i>So Balto. Md.</i>					
15 Filed <i>May 24<sup>th</sup>, 1914</i>		16 REGISTRAR <i>T. B. Horton Md.</i>			
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>May 24</i> , 191 <i>4</i> (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended deceased from <i>April 25<sup>th</sup>, 1914</i> , to <i>May 24<sup>th</sup>, 1914</i> , that I last saw her alive on <i>May 23<sup>rd</sup>, 1914</i> , and that death occurred on the date stated above, at <i>9:15 a.m.</i>			
The CAUSE OF DEATH* was as follows: <i>Broncho Pneumonia</i> <i>Acute Nephritis</i> (Duration) <i>4</i> yrs. <i>4</i> mos. <i>15</i> ds.					
Contributory Secondary		(Signed) <i>Thomas B. Horton</i> , M. D. <i>May 24<sup>th</sup>, 1914</i> (Address) <i>So Balto. Md.</i>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence. _____					
19 PLACE OF BURIAL OR REMOVAL <i>Oak Hill</i>		DATE OF BURIAL <i>May 26<sup>th</sup>, 1914</i>			
20 UNDERTAKER <i>Frank Vach &amp; Son</i>		ADDRESS <i>404 Ashland Ave</i>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

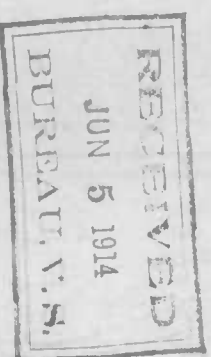
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4545

 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

County

Anne Arundel

Registered No.

21

 New Pasadena Station B&O RR 3<sup>d</sup> Edition District  
 Village or City

 [If death occurred in  
 a hospital or institution,  
 give its NAME instead  
 of street and number.]

FULL NAME

George Shaw

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

(about) 50 years

 If LESS than  
 1 day, .... hrs.  
 yrs. .... mos. .... ds. OR .... min. ?

8 OCCUPATION

 (a) Trade, profession, or  
 particular kind of work.

Gen. Laborer, machanic

(b) General nature of industry, or nature of service, business, or establishment in which employed (or employer)

on farm of Edward Green New Pasadena Station B&amp;O RR

9 BIRTHPLACE

(State or country)

Baltimore, but for some years has lived in Baltimore, Md. (So State)

10 NAME OF FATHER

John Gulhrich the Informant

## PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) John Gulhrich now residing business on farm of Edward Green His home is at 1005 N. 8<sup>th</sup> St. Wilmington, Del.

15

Filed May 31, 1914 J. S. Billingsley

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 30

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at about 5 A. M.

The CAUSE OF DEATH\* was as follows:

He died suddenly sitting in a chair. He had been suffering for a long time with "heart disease." Probable cause of death "Heart Disease."

He told (the informant) that he had been in "Mercy Hospital Baltimore" for a month or more, prior to May 15-1914.

(Signed) Melville S. Dunslop, M.D. acting Coroner

191 (Address) 2401 A St. S.E.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. .... mos. .... ds. In the State yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Edward Green's farm near Pasadena Station B&amp;O RR

DATE OF BURIAL

May 31, 1914

20 UNDERTAKER

J. S. Billingsley

ADDRESS

—

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

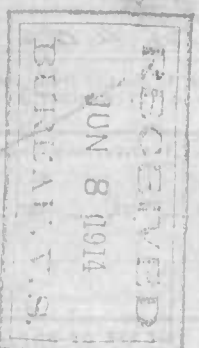
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1 PLACE OF DEATH 4546  
 County A-A-  
 Village or City Annapolis (No. 74 Cathedral St.; 2 Ward)  
 2 FULL NAME Ester Simms  
 Registration Dist. No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single  
 6 DATE OF BIRTH April 25, 1914  
 (Month) (Day) (Year)  
 7 AGE 29 yrs. — mos. — ds. OR LESS than 1 day, — hrs. — min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Annapolis Ind.

10 NAME OF FATHER Benjamin Simms  
 11 BIRTHPLACE OF FATHER (State or country) Annapolis Ind.  
 12 MAIDEN NAME OF MOTHER Willy Colbert  
 13 BIRTHPLACE OF MOTHER (State or country) A-A- Co., Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Benjaminine Simms  
 (Address) 74 Cathedral St.

15 Filed May 4, 1914 Jms Welch  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1914 to May 4, 1914, that I last saw her alive on May 3, 1914.

and that death occurred on the date stated above, at \_\_\_\_\_ m.  
 The CAUSE OF DEATH\* was as follows:

Pneumonia Berth  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory \_\_\_\_\_  
 Secondary \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. Charles Purvis, M. D.  
May 4, 1914. (Address) Annapolis Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Asbury Cemt. DATE OF BURIAL 5-5, 1914

20 UNDERTAKER E. B. Parker & Son. ADDRESS 92 West St.  
Dr Purvis

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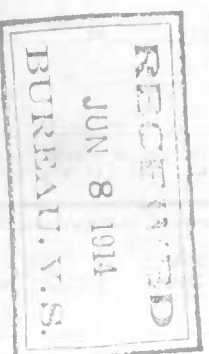
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1 PLACE OF DEATH 4547  
 County Anne Arundel  
 Village or City East-Port- (No. 481, Severn Ave St.; 21 Ward)  
 Registration Dist. No. 21  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Francis M. Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 29, 1913  
 (Month) (Day) (Year)

7 AGE 9 yrs. 3 mos. 3 ds. If LESS than 1 day, .... hrs. OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER (State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER (State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15

Filed

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

May 30, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 15th, 1914, to May 2nd, 1914.

that I last saw him alive on May 2nd, 1914.

and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
 (Duration) .... yrs. .... mos. 18 ds.

## Contributory (Secondary)

(Signed) J. T. Russell, M. D.  
May 3rd, 1914 (Address) Eastport, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. to the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

West-River A.A. Co. May 4, 1914

## 20 UNDERTAKER

## ADDRESS

Shooley & Son 12 Murray Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1 Annapolis Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

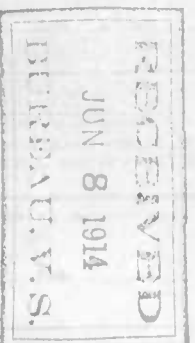
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County aa

4548

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Eastport (No. Fourth St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Smith

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH May 30, 1914  
(Month) (Day) (Year)

7 AGE 23 yrs. 23 mos. 23 ds. It LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Eastport 990 Ma

## PARENTS

10 NAME OF FATHER Moses Smith

11 BIRTHPLACE OF FATHER (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Josephine Adams

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josephine Adams  
Eastport aa Co  
(Address) Ma

15 Filed May 25, 1914 M. S. Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23<sup>rd</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914 to May 23<sup>rd</sup>, 1914.

that I last saw him alive on May 23<sup>rd</sup>, 1914.

and that death occurred on the date stated above, at 10 A m.

The CAUSE OF DEATH\* was as follows:

congenital  
Debility.  
Since birth (Duration) yrs. mos. ds.

Contributory Exhaustion  
Secondary Gradual (Duration) yrs. mos. ds.

(Signed) John Ridout, M. D.  
May 25, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Brewer Hill Cent DATE OF BURIAL May 25, 1914

20 UNDERTAKER Gas S. Taylor Sons ADDRESS Annapolis Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

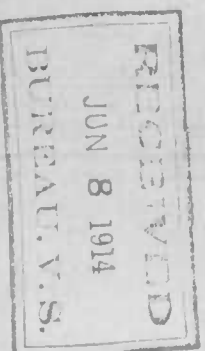
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4549

County

G. G.

Village or City

So. Balt.

(No. 26, Church

St.; Ward)

Registration Dist. No.

74

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Anton Soustek

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

Sept. 25, 1912

7 AGE

1 yrs. 7 mos. 20 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

So. Balt.

PARENTS

10 NAME OF FATHER

Frank Soustek

11 BIRTHPLACE OF FATHER (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Anna Schmidt

13 BIRTHPLACE OF MOTHER (State or country)

Bohemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Soustek

(Address)

26 Church St. Curtis Bay, Md.

15

Filed

May 17, 1914 Thos. B. Norton MD

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 15, 1914

17

I HEREBY CERTIFY, That I attended deceased from

May 8, 1914, to May 15, 1914, that I last saw him alive on May 15, 1914, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH\* was as follows:

Broncho Pneumonia  
 Bronchopneumonia  
 Str. 243- (Duration) 5 yrs. 5 mos. 5 ds.  
 Contributory Accidentally burned  
 Secondary (Duration) 17 yrs. 7 mos. 17 ds.  
 (Signed) Thos. B. Norton, M. D.  
 May 17, 1914 (Address) So. Baltimore Sta., Curtis Bay, Md.

\*State the DISEASE CAUSING DEATH, and the MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Cross

May 18, 1914

20 UNDERTAKER

ADDRESS

Frank Crachley

1904-6 Ashland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

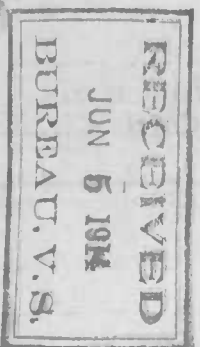
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4550  
 County Anne Arundel  
 near Brooklyn (No. 272) St.; Ward)  
 Village or City near Mary Lizzie Stevens  
 2 FULL NAME Mary Lizzie Stevens  
 Registration Dist. No. 23  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Cold 5 SINGLE, Married, Widowed, Divorced (Write the word) Lush  
 6 DATE OF BIRTH April 13, 1900 (Month) (Day) (Year)  
 7 AGE 14 yrs. 1 mos. 0 ds. OR 1 LESS than 1 day, 0 hrs. 0 min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work School girl  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) AAW Md

PARENTS  
 10 NAME OF FATHER James Henry Stevens  
 11 BIRTHPLACE OF FATHER (State or country) Maryland  
 12 MAIDEN NAME OF MOTHER Eliza Wright  
 13 BIRTHPLACE OF MOTHER (State or country) AAW Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Eliza Stevens  
 (Address) Brooklyn 272

15 Filed May 11, 1914 Thomas A. Bryner REGISTRAR  
Daphne

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 11, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1914, to May 11, 1914, that I last saw her alive on May 8, 1914,

and that death occurred on the date stated above, at 6 P. m.  
 The CAUSE OF DEATH\* was as follows:

Tuberculosis of Both Lungs  
 (Duration) 6 yrs. 0 mos. 0 ds.

Contributory Secondary Same  
 (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Thos A Bryner, M. D.  
May 11, 1914 (Address) Eliz Stevens

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
 At place of death 14 yrs. 0 mos. 0 ds. In the an her life State 0 yrs. 0 mos. 0 ds.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Green Branch DATE OF BURIAL May 14, 1914  
 20 UNDERTAKER Parkman & Co ADDRESS Eliz Stevens

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

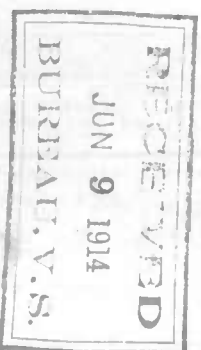
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercle of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc.; State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4551  
 County Anne Arundel  
 Village or City Jessup (No. md) St.; Ward  
 2 FULL NAME D. Claude A. Stonecipher  
 Registration Dist. No. 22  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>Dec. 16<sup>th</sup></u> , 188 <u>1</u> (Month) (Day) (Year)		
7 AGE <u>33</u> yrs. — mos. — ds.		It LESS than 1 day.....hrs. OR.....min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Physician</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Carroll Co. Md</u>		
PARENTS	10 NAME OF FATHER <u>Wm. A. Stonecipher</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Carroll Co. Md</u>	
	12 MAIDEN NAME OF MOTHER <u>Lucretia Ann</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Carroll Co. Md</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr S. A. Pollock

(Address)

3407 Potomac Falls Rd

15

Filed

May 29<sup>th</sup> 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28<sup>th</sup>, 1914  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, That I attended deceased from Nov 10<sup>th</sup>, 1914, to May 29<sup>th</sup>, 1914,  
 that I last saw him alive on May 29<sup>th</sup>, 1914,  
 and that death occurred on the date stated above, at 7<sup>00</sup> m.  
 The CAUSE OF DEATH\* was as follows:

Chronic Bright's Disease  
 (Duration) yrs. 7 mos. — ds.  
 Contributory (Secondary) Dropsey  
 (Duration) yrs. 6 mos. — ds.  
 (Signed) J. R. Ryals, M. D.  
May 29, 1914 (Address) Faurel Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. — mos. — ds. In the State 33 yrs. — mos. — ds.  
 Where was disease contracted, if not at place of death? at home  
 Former or usual residence: 1535 N. Fulton Baltimore

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Westminster June 2, 1914

20 UNDERTAKER ADDRESS

W. J. Tucker & Son North Penn

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 da.; *Bronchopneumonia* (secondary), 10 da. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4552

County A. A.

177 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21Village or City Annapolis (No. 18, Randall St.; 1 Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME Carl Leslie Taylor

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 11, 1914  
(Month) (Day) (Year)

7 AGE 42 yrs. 29 mos. 30 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Annapolis Md

PARENTS

10 NAME OF FATHER

Prover Taylor

11 BIRTHPLACE OF FATHER (State or country)

Knoxville, Tenn.

12 MAIDEN NAME OF MOTHER

Helen Finkle

13 BIRTHPLACE OF MOTHER (State or country)

Annapolis Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Prover Taylor

(Address)

Annapolis Md

15

Filed May 11, 1914Dr. S. Melch

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 10, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from May 5, 1914, to May 10, 1914.

that I last saw him alive on May 9, 1914

and that death occurred on the date stated above, at 7 A m.

The CAUSE OF DEATH\* was as follows:

Acute myocarditis(Duration) yrs. 1 mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) J. C. Taylor, M. D.May 11, 1914 (Address) Annapolis

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Naval CemMay 11, 1914

20 UNDERTAKER

ADDRESS

Jas S. Taylor & SonsAnnapolis

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

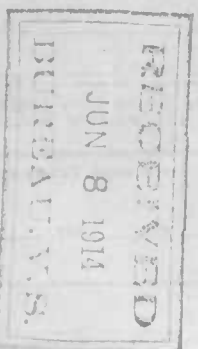
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Rum Rundi</u> <u>4553</u>			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>21</u>		
Village or City <u>Annapolis</u> (No. <u>42</u> , <u>Randall</u> St.; <u>1</u> Ward)			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
2 FULL NAME <u>Taylor</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>May 8, 1914</u> (Month) (Day) (Year)					
7 AGE _____ yrs. _____ mos. <u>1</u> ds. <u>It LESS than 1 day, 2 hrs. OR min. ?</u>					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Annapolis Md</u>					
PARENTS					
10 NAME OF FATHER <u>W. H. Taylor Jr</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Annapolis Md</u>					
12 MAIDEN NAME OF MOTHER <u>May Elenora Smith</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>A. C. Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. H. Taylor Jr</u> (Address) <u>Annapolis Md</u>					
15 Filed <u>May 10, 1914</u> <u>Jms Welch</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 9, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 8, 1914</u> , to <u>May 9, 1914</u> , that I last saw him alive on <u>May 9, 1914</u> , and that death occurred on the date stated above, at <u>11:30 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Premature Birth</u> <u>6 months</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Walton H. Hopkins</u> , M. D. <u>May 10, 1914</u> (Address) <u>Annapolis Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>St Annas Cent</u> DATE OF BURIAL <u>May 10, 1914</u>					
20 UNDERTAKER <u>Jas S. Taylor &amp; Sons</u> ADDRESS <u>Annapolis Md</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

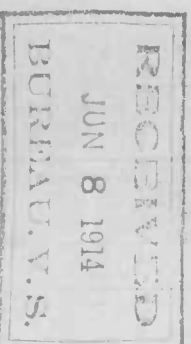
Approved by U. S. Census and American Public Health Association.<sup>1</sup>

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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Ræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4554  
 County Anne Arundel  
 Village or City Fairfield (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)  
 2 FULL NAME John W. Teeter

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 24

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Unknown, 1847  
 (Month) (Day) (Year)

7 AGE about 67 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer) Jno. H. Zeis & Co.

9 BIRTHPLACE (State or country) Rockingham County, Va.

10 NAME OF FATHER John W. Teeter, Sr.

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Crane

13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Marion Ed. Teeter

(Address) Baltimore, Md.

15 Filed May 1<sup>st</sup> 1914 John B. Norton REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 1<sup>st</sup>, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH\* was as follows:

Acute Indigestion  
 (Duration) 45 min.

Contributory (Secondary) \_\_\_\_\_

(Signed) Frank A. Wolfram, Acting Coroner  
May 1<sup>st</sup> 1914 (Address) Baltimore, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Martinsburg, West Va. May 3<sup>rd</sup> 1914

20 UNDERTAKER ADDRESS

Madison E. Mitchell Balto., Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

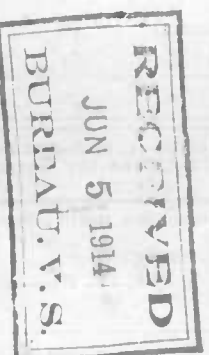
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4555

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County Anne Arundell

Registration Dist. No. 21

Village or City Annapolis (No. Emergency Hospital St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John W. Thomas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown  
(Month) (Day) (Year)

7 AGE 29 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Driver (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Unknown

PARENTS 10 NAME OF FATHER Unknown 11 BIRTHPLACE OF FATHER (State or country) Unknown 12 MAIDEN NAME OF MOTHER Unknown 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Feldmeyer

(Address) 124 College Ave

15 Filed May 28, 1914 Wm S Welch

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1914, to May 27, 1914.

that I last saw him alive on May 27, 1914

and that death occurred on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH\* was as follows:

Total Pneumonia

Contributory  
Secondary

(Duration) Unknown yrs. mos. ds.  
(Signed) Wallon H. Harker, M. D.  
May 28, 1914 (Address) Annapolis Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Brewer Hall DATE OF BURIAL 5/28, 1914

20 UNDERTAKER The Defeld & Hopping ADDRESS 118 Cathedral

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. G. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

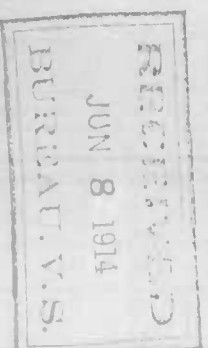
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc., State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4556

184 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 20

County Anne Arundel

Village or City Harwood (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Daniel Tongue

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH May 8, 1914 (Month) (Day) (Year)

7 AGE It LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER Maryland Richard Tongue

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Monland

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Tongue

(Address) Harwood, Md.

15

Filed May 19, 1914 William Cawood

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1914, to May 19, 1914, that I last saw him alive on May 18, 1914, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH\* was as follows:

unknown

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Unknown Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) William Cawood, M. D.

May 19, 1914 (Address) West River, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Daniel Star Cemetery May 19, 1914

20 UNDERTAKER ADDRESS

Wm Morris Talbot West River, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

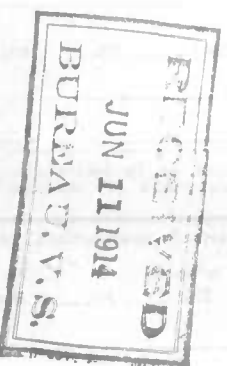
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4557

County Anne Arundel

189 STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 20Village or City Harwood (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME No Name - Child of Daniel Tongue

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 27 27, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, 2 hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Daniel Tongue

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Orucilla Tongue

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Tongue(Address) Harwood, Md.

15 Filed May 29, 1914 Magnum Curwood  
Dep. Local REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from I did not attend, 1914

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 1914

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

unknown

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory unknown  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Magnum Curwood, M. D.  
May 29, 1914. (Address) West River, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL

Mrs Sam Brady's Farm DATE OF BURIAL May 29, 1914

20 UNDERTAKER

Daniel Tongue ADDRESS Harwood, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

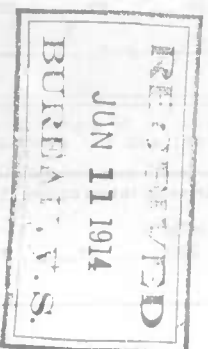
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4558

County Anne Arundel  
Shore of Magothy River  
 Village or City Rock Creek (No. \_\_\_\_\_)

169 STATE OF MARYLAND  
 CERTIFICATE OF DEATH

Registration Dist. No. 2-1

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Not Known

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Not Known

6 DATE OF BIRTH Not Known  
 (Month) (Day) (Year)

7 AGE about 35 years  
 If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Not Known  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Not Known

PARENTS  
 10 NAME OF FATHER Not Known  
 11 BIRTHPLACE OF FATHER (State or country) Not Known  
 12 MAIDEN NAME OF MOTHER Not Known  
 13 BIRTHPLACE OF MOTHER (State or country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. F. Minnick, Justice of the Peace  
 (Address) Annapolis, Maryland

15 Filed May 15, 1914 Wm. S. Malach  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May, 1914  
 (Month) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Cause unknown supposed to be accidental drowning

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Wm. F. Minnick, Justice of the Peace  
May 15, 1914 (Address) Annapolis

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Brewer Hill Cem. DATE OF BURIAL May 16, 1914

20 UNDERTAKER Geo. S. Taylor Sons ADDRESS Annapolis



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>St. H.</u> 4559		157 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>St. Balto</u> (No. _____) St. _____ Ward _____		Registration Dist. No. <u>24</u>	
2 FULL NAME <u>Fred Vogelsang</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>Feb 14, 1880</u> (Month) (Day) (Year)			
7 AGE <u>34</u> yrs. <u>3</u> mos. <u>17</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Clerk in Dry Goods Store</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Balto. Md</u>			
PARENTS	10 NAME OF FATHER <u>Geo. Vogelsang</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>		
	12 MAIDEN NAME OF MOTHER <u>Caroline Demick</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Md</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Fred Vogelsang</u> (Address) <u>1616 Jackson St. Balto</u>			
15 FILED <u>May 31<sup>st</sup> 1914</u> <u>Thos. B. Horton</u> MD REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 31<sup>st</sup>, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY that I attended deceased from _____, 191____, to _____, 191____.			
that I last saw h. _____ alive on _____, 191____.			
and that death occurred on the date stated above, at _____ m.			
The CAUSE OF DEATH* was as follows: <u>Strangulation</u> <u>Suicide by Hanging</u> (Duration) _____ yrs. _____ mos. _____ ds.			
Contributory _____ Secondary _____			
(Signed) <u>James H. Howley</u> acting coroner <u>May 31<sup>st</sup>, 1914</u> (Address) <u>Brooklyn, Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Cedar Hill Cemetery</u>		DATE OF BURIAL <u>June 2<sup>nd</sup>, 1914</u>	
20 UNDERTAKER <u>D. M. Flynn</u>		ADDRESS <u>Balto. Md</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

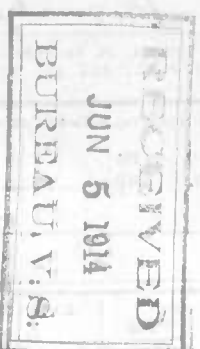
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not faithfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæ-mia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4560

County

C. C.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No.

22

Village or City

Woodwardsville

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ella ~~Anderson~~ ~~Woodward~~ ~~Wabaro~~

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *married*

6 DATE OF BIRTH

*about*, 1856  
(Month) (Day) (Year)

7 AGE

58 yrs. — mos. — ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

*Maryland*

## PARENTS

10 NAME OF FATHER

*Richard Anderson*

11 BIRTHPLACE OF FATHER (State or country)

*Maryland*

12 MAIDEN NAME OF MOTHER

*Sarah A. Woodward*

13 BIRTHPLACE OF MOTHER (State or country)

*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Wm Anderson*

(Address)

*Woodwardsville*

15

Filed

*May 26th*, 1914 *Shaw*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May**25*

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*May 1*, 1914 to *May 25*, 1914that I last saw her alive on *May 25*, 1914and that death occurred on the date stated above, at *3 P* m.

The CAUSE OF DEATH\* was as follows:

*Dr. J. H. McElroy*(Duration) *3* yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

*J. H. McElroy*

M. D.

*May 25*, 1914 (Address) *Perryman Rd*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Trinity Cemetery* *May 27*, 1914

20 UNDERTAKER

ADDRESS

*Coats* *Balto. Md.*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

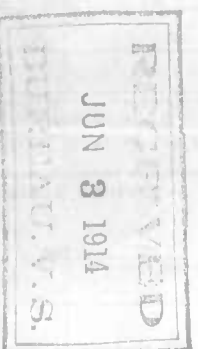
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH

4561

County A. A.Gelhaus Row

152  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 21Village or City Germantown (No. 62 Spa Road St.; — Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

2 FULL NAME Henrietta Wallace

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 19, 1914  
(Month) (Day) (Year)

7 AGE 3 yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Germantown, A. A., Co. Md.

PARENTS  
10 NAME OF FATHER Richard Whisen  
11 BIRTHPLACE OF FATHER (State or country) Annapolis Md.  
12 MAIDEN NAME OF MOTHER Henrietta Wallace  
13 BIRTHPLACE OF MOTHER (State or country) Annapolis Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henrietta Wallace(Address) 62 Spa Road, Germantown, Md.

15 Filed May 23, 1914 Jms Welch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 22, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1914, to May 22, 1914, that I last saw her alive on May 22, 1914

and that death occurred on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH\* was as follows:

Umbilical Hemorrhage

Contributory Exhaustion  
Secondary

(Signed) Louis B. Stenwick, M. D.  
May 23, 1914 (Address) Annapolis, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Sage Bottom DATE OF BURIAL 5/23, 1914

20 UNDERTAKER Wildfield & Hopping ADDRESS Annapolis Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

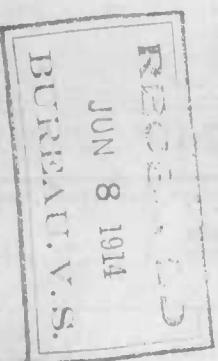
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1 PLACE OF DEATH County <u>Adm.</u>		4562	(90)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Annapolis</u> (No. <u>126</u> , <u>City Dock</u> St.; Ward)			Registration Dist. No. <u>21</u>		[It death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Katherine Williams</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)				
6 DATE OF BIRTH <u>March 9</u> , 18 <u>35</u> (Month) (Day) (Year)						
7 AGE <u>79</u> yrs. <u>2</u> mos. <u>4</u> ds.				It LESS than 1 day.....hrs. OR.....min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>England</u>						
PARENTS	10 NAME OF FATHER <u>Peter O'Brien</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>					
	12 MAIDEN NAME OF MOTHER <u>Katherine McQueeney</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Annie Sander</u> (Address) <u>126 City Dock</u>						
15 Filed <u>May 15</u> , 191 <u>4</u>		REGISTRAR <u>Wm. S. Welch</u>				
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>5</u> / <u>3</u> , 191 <u>4</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended deceased from <u>March 15</u> , 191 <u>4</u> , to <u>May 13</u> , 191 <u>4</u> , that I last saw him alive on <u>May 12</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9:30 a</u> m.						
The CAUSE OF DEATH* was as follows: <u>Acute Bronchitis</u> <u>Pneumonia</u>						
(Duration) <u>3</u> yrs. <u>3</u> mos. <u>—</u> ds.						
Contributory Secondary						
(Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.						
(Signed) <u>J. S. Smith</u> , M. D. <u>May 15</u> , 191 <u>4</u> (Address) <u>Annapolis</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? <u>—</u> Former or usual residence <u>—</u>						
19 PLACE OF BURIAL OR REMOVAL <u>Saint Mary's Cemetery</u>				DATE OF BURIAL <u>5/16</u> , 191 <u>4</u>		
20 UNDERTAKER <u>Widfield &amp; Hopping</u>				ADDRESS <u>Annapolis</u>		
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.						

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

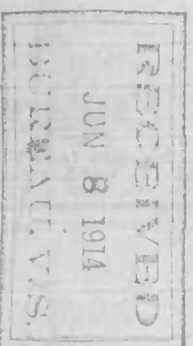
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <i>At Home</i>		4563		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Frederick</i>		Village or City <i>Fairfield</i>		Registration Dist. No. <i>24</i>	
2 FULL NAME <i>Dead Born Wischer</i>		No. <i>1</i>		St.; Ward) <i>(If death occurred in a hospital or institution, give its NAME instead of street and number.)</i>	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <i>Widder</i>			
6 DATE OF BIRTH <i>May 23<sup>rd</sup>, 1914</i>		(Month) (Day) (Year)			
7 AGE <i>1</i> yrs. <i>1</i> mos. <i>1</i> ds.		It LESS than 1 day, <i>1</i> hrs. OR <i>1</i> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <i>Fairfield, Md.</i>					
PARENTS	10 NAME OF FATHER <i>John G. Wischer</i>				
	11 BIRTHPLACE OF FATHER (State or country) <i>Balto, Md.</i>				
	12 MAIDEN NAME OF MOTHER <i>Rose V. Spencer</i>				
13 BIRTHPLACE OF MOTHER (State or country) <i>Phila.</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>John G. Wischer</i> (Address) <i>Fairfield, Md.</i>					
15 FILED <i>May 23<sup>rd</sup>, 1914</i> <i>John B. Horton</i> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>May 26<sup>th</sup>, 1914</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>May 23<sup>rd</sup>, 1914</i> to <i>May 26<sup>th</sup>, 1914</i> , 1914, that I last saw him alive on <i>May 23<sup>rd</sup>, 1914</i> , 1914, and that death occurred on the date stated above, at <i>1</i> m. The CAUSE OF DEATH* was as follows: <i>Dead Born</i> (Duration) <i>1</i> yrs. <i>1</i> mos. <i>1</i> ds.					
Contributory Secondary (Signed) <i>John B. Horton</i> , M.D. <i>May 23<sup>rd</sup>, 1914</i> (Address) <i>So. Balto., Md.</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>1</i> yrs. <i>1</i> mos. <i>1</i> ds. In the State <i>1</i> yrs. <i>1</i> mos. <i>1</i> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <i>Holy Cross Cemetery</i>				DATE OF BURIAL <i>May 23<sup>rd</sup>, 1914</i>	
20 UNDERTAKER <i>John J. Fisher</i>				ADDRESS <i>Balto., Md.</i>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto. Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

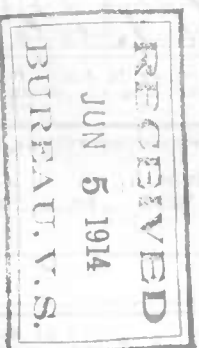
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 4564  
 County Anne Arundel  
 Village or City Crownsville State Hospital (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
**2 FULL NAME** Sadie Wright  
 Registration Dist. No. 21  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Female **4 COLOR OR RACE** Black **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single  
 (Write the word)  
**6 DATE OF BIRTH** Unknown, 1879  
 (Month) (Day) (Year)  
**7 AGE** 35 yrs. Unknown mos. Unknown ds. If LESS than 1 day, hrs. OR min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Laundress  
 (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE** (State or country) Maryland

**PARENTS**  
**10 NAME OF FATHER** Unknown  
**11 BIRTHPLACE OF FATHER** (State or country) Unknown  
**12 MAIDEN NAME OF MOTHER** Unknown  
**13 BIRTHPLACE OF MOTHER** (State or country) Unknown

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Hospital  
 (Address) Records

**15** Filed 5/12, 1914 by J. D. Joyce  
 Deputy Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** May 10, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY**, That I attended deceased from Oct. 4, 1913, to May 10, 1914.

that I last saw him alive on May 10, 1914.

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

Pulmonary Tuberculosis  
 (Duration) Unknown yrs. Unknown mos. Unknown ds.

Contributory  
 Secondary

(Signed) Robert P. McIntosh, M. D.  
May 11, 1914 (Address) Crownsville Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE** (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 8 yrs. 6 mos. 6 ds. In the State Life yrs. Life mos. Life ds.

Where was disease contracted, Unknown  
 If not at place of death?

Former or usual residence Hent County, Md

**19 PLACE OF BURIAL OR REMOVAL** Hospital Cemetery **DATE OF BURIAL** 5-12, 1914

**20 UNDERTAKER** R. P. Winchell Supt. **ADDRESS** Crownsville Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

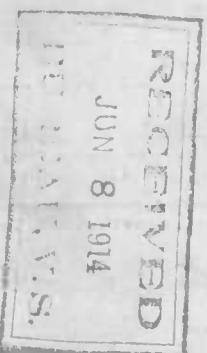
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4565

County aaVillage or City Brooklyn (No. 188)

2 FULL NAME

Rebecca WrightSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 205

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Don't know  
(Month) (Day) (Year)

7 AGE 56 yrs. 56 mos. 56 ds. If LESS than 1 day... hrs. OR... min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Ind

PARENTS  
10 NAME OF FATHER Saml. Anderson  
11 BIRTHPLACE OF FATHER (State or country) Ind  
12 MAIDEN NAME OF MOTHER Sarah Jane Wright  
13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Williams(Address) Brooklyn

15 Filed May 15, 1914 Shastbrook

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 15, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191—, to —, 191—,

that I last saw h — alive on —, 191—.

and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH\* was as follows:

Sudden Death  
in attendance (Duration) 20 h yrs. — mos. — ds.

Contributory (Secondary) — (Duration) — yrs. — mos. — ds.

(Signed) Joseph H. Joadwin M.D.  
May 15, 1914 (Address) Brooklyn

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
Furnace Branch May 15, 1914

20 UNDERTAKER ADDRESS  
John H. Joadwin 142 Hotel

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Approved by U. S. Census and American Public Health Association.]

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